For OHR use only

Department_____

Position_____

☐ **Check here if this is a temporary/seasonal position.**

OHR Specialist_____

MONTGOMERY COUNTY, MARYLAND
REPORT OF APPLICANT'S
MEDICAL HISTORY
OCCUPATIONAL MEDICAL SERVICES
(240) 777-5118 Fax (240) 777-5132

You have received an offer of employment conditioned on the result of this medical evaluation. This form is to be completed and sent to Occupational Medical Services (OMS) within 3 business days. Your employment application will not be further processed until OMS receives and evaluates this completed report, which is considered part of your application. The information provided will be maintained in confidential medical files and will be reviewed only by Occupational Medical Services or other authorized persons. Please print and use ink to complete this form.

LAST NAME - FIRST NAME - MIDDLE NAME POSITION APPLIED FOR

HOME ADDRESS - STREET CITY STATE ZIP SOCIAL SECURITY #

HOME TELEPHONE OFFICE TELEPHONE DATE OF BIRTH AGE SEX

In emergency, notify: (name, address, phone)

Personal physician/health care provider or clinic: (name, address, phone)

Statement of your present health in your own words:

Date of last physical examination:_____

Date of last chest x-ray or TB test:_____

Have you been medically evaluated by Montgomery County in the past as a job applicant? ___YES ___NO
If YES, state date and position:

Are you currently experiencing significant symptoms of ill health? ___YES ___NO
If YES, explain:

Do you currently have any physical or mental condition that may limit your ability to perform the job for which you have applied? ___YES ___NO
If YES, explain:

If driving is an element of this job, have you any medical or other restriction pertaining to driving a motor vehicle? ___YES ___NO
If YES, give date(s) and explain:

Are you currently disabled in any way that may affect your ability to perform this job? ___YES ___NO
If YES, explain:

Do you have any condition requiring a reasonable accommodation in order for you to perform this job? ___YES ___NO
If YES, explain:

In the past two years, have you been unable to work for a period longer than one week due to illness or injury? ___YES ___NO
If YES, give date(s) and explain:

Have you been refused employment or been terminated from a job due to:
a. sensitivity to chemicals, dust, sunlight, etc.
b. inability to perform certain motions
c. inability to assume certain positions
d. any other medical, emotional, or physical reason? ___YES ___NO
If YES, give date(s) and explain:

Have you within the past 5 years, had to change jobs because of an injury, illness, or diagnosed medical condition?

___YES ___NO

If YES, give date(s) and explain:

Have you consulted with or been treated by physicians, therapists, chiropractors, or other practitioners within the past five years? ___YES ___NO

If YES, give date(s) and explain:

Have you been a patient in a hospital or rehabilitation center within the past five years? ___YES ___NO

If YES, give date(s) and explain:

Have you, within the past five years, been advised to have a surgical operation that you declined to have? ___YES ___NO

If YES, give date(s) and explain:

Within the past five years, have you been diagnosed or treated by a health care provider for any of the following:

1. Abnormal Chest X-ray	____YES	____NO	35. Slipped/Ruptured Disc	___YES	___ NO
2. Abnormal EKG	____YES	____NO	36. Loss of Limb/Finger/Toe	___YES	___ NO
3. Allergies	____YES	____NO	37. Significant Tremors/ Shaking	___YES	___ NO
4. Blood in Urine	____YES	____NO	38. Sciatica or Neuritis	___YES	___ NO
5. Bone Disease	____ YES	____NO	39. Arthritis or Gout	___YES	___ NO
6. Chronic Sleep Disorder	____YES	____NO	40. Dizziness/Fainting	___YES	___ NO
7. Chronic Cough	____ YES	____NO	41. Fractured Bone	___YES	___ NO
8. Chronic Diarrhea	____ YES	____NO	42. Severe Headaches	___YES	___ NO
9. Collapsed Lung	____ YES	____NO	43. Psychological/Mental Condition	___YES	___ NO
10. Detached retina	____ YES	____NO	44. Hearing Impairment	___YES	___ NO
11. Diabetes	____ YES	____NO	45. Cataracts	___YES	___ NO
12. Tuberculosis	____ YES	____NO	46. Knee/leg/ankle/foot Condition	___YES	___ NO
13. Stomach Ulcer	____ YES	____NO	47. Shoulder/arm Condition	___YES	___ NO
14. Varicose Veins	____ YES	____NO	48. Speech Impairment	___YES	___ NO
15. Wheezing/Asthma	____ YES	____NO	49. Post Traumatic Stress (PTSD)	___YES	___ NO
16. Yellow Jaundice	____ YES	____NO	50. Paralysis	___YES	___ NO
17. Gall Bladder Condition	____ YES	____NO	51. Back or Neck Pain	___YES	___ NO
18. Heart Attack	____ YES	____NO	52. Rash or Skin Condition	___YES	___ NO
19. Heart Murmur	____ YES	____NO	53. Loss of consciousness	___YES	___ NO
20. Thyroid Condition	____ YES	____NO	54. Anemia	___YES	___ NO
21. High Blood Pressure	____ YES	____NO	55. Cancer or Tumor	___YES	___ NO
22. High Cholesterol	____ YES	____NO	56. Clinical Depression	___YES	___ NO
23. Hypoglycemia	____ YES	____NO	57. Hernia	___YES	___ NO
24. Stroke	____ YES	____NO	58. Head Injury	___YES	___ NO
25. Intestinal Condition	____ YES	____NO	59. Alcoholism	___YES	___ NO
26. Kidney/UTI condition	____ YES	____NO	60. Epilepsy/Seizure	___YES	___ NO
27. Liver Disease	____ YES	____NO	61. Learning Disability	___YES	___ NO
28. Rheumatic Fever	____ YES	____NO	62. Drug Addiction	___YES	___ NO
29. Heart Palpitations	____ YES	____NO	63. Chronic Fatigue	___YES	___ NO
30. Pancreatitis	____ YES	____NO	64. Memory Impairment	___YES	___ NO
31. Phlebitis/Blood Clot	____ YES	____NO	65. Swollen/Painful Joint	___YES	___ NO
32. Pneumonia	____ YES	____NO	66. Bursitis	___YES	___ NO
33. Poor Night Vision	____ YES	____NO	67. Bleeding Disorder	___YES	___ NO
34. Prostate Cancer	____ YES	____NO			

Explain all YES answers by number. Be sure to include dates and types of treatments, where applicable.

Have you within the past 5 years, perceived that you have had, or have you actually experienced, the following:

1. Wheezing/Asthma	____ YES	____NO	10. Leg Pain	___YES	___ NO
2. Hemorrhoids	____ YES	____NO	11. Fear of Heights	___YES	___ NO
3. Chest Pain/Pressure	____ YES	____NO	12. Diminished Night Vision	___YES	___ NO
4. Heart Palpitations	____ YES	____NO	13. Frequent Dizziness/Fainting	___YES	___ NO
5. Double Vision	____ YES	____NO	14. Significant Tremors/ Shaking	___YES	___ NO
6. Shortness of Breath	____ YES	____NO	15. Fear of Close Spaces	___YES	___ NO
7. Frequent Indigestion	____ YES	____NO	16. Frequent Infections	___YES	___ NO
8. Poor Urine Control	____ YES	____NO	17. Significant Back or Neck Pain	___YES	___ NO
9. Significant Intestinal Discomfort	____ YES	____NO	18. Recent Substantial Weight Change	___YES	___ NO

Explain all YES answers by number. Be sure to include dates and types of treatments, where applicable.

Allergies may be insignificant in childhood but may have serious consequences in later life. Please help us by checking all allergies that apply:

☐Food
☐Soaps or detergents
☐Metals, chromium
☐Nickel
☐Rubber
☐Epoxy resins
☐Plants (poison ivy)
☐Bee stings
☐Pollen
☐Insect scales
☐Animal dander
☐House Dust
☐Industrial chemicals
☐Others:

Have you been immunized against:

Hepatitis B	__Yes __No	Tetanus	__Yes __No
Rubella(German measles)	__Yes __No	Mumps	__Yes __No
Varicella (Chicken Pox)	__Yes __No	Rubeola (Measles)	__Yes __No
Polio	__Yes __No	Rabies	__Yes __No
		Other	__Yes __No

For applicants/employees requiring a physical exam that may include strenuous physical ability/agility testing, x-rays, immunizations, etc., please indicate if you are pregnant or suspect that you are pregnant? ___Yes ___No

Do you wear glasses, contact lenses, or an artificial eye? ___Yes ___No
If Yes, circle as appropriate.
If wearer of contact lenses, indicate whether: ___Soft ___Hard

Are you a wheelchair user or do you use an assistive device (i.e. cane, crutches, walker, or artificial limb)?
If Yes, circle as appropriate ___Yes ___No

Do you wear a hearing aid? ___Yes ___No

Are you currently taking prescription medications? ___Yes ___No
If Yes, please list:

Are you currently taking over the counter medications that may cause drowsiness (e.g. decongestants, antihistamines, cough suppressants)? ___Yes ___No
If Yes, please list:

Are you currently on any special diets recommended by a health care provider?
If Yes, Explain: ___Yes ___No

Have you ever smoked or used tobacco of any type? ___Yes ___No
Do you smoke now? ___Yes ___No
If yes, to either question:
How long and how much?

Do you drink alcoholic beverages? ___Yes ___No
If Yes, Circle: daily or weekly
If Yes, Describe daily or weekly amount:

Within the past 5 years, have you been advised by a health care provider to reduce your consumption of alcohol because of a health condition resulting from or made worse by drinking alcohol?
If Yes, Explain: ___Yes ___No

To the best of your knowledge, have you had a significant exposure to any of the following either in your work or while engaged in a hobby?

1. Mercury (scientific instruments, chlorine plants, dental offices) ___Yes ___No
2. Arsenic (insecticides) ___Yes ___No
3. Acrylamide (construction, grouting) ___Yes ___No
4. Hexane (solvents, rubber cements, inks) ___Yes ___No
5. Trichloroethylene (trichlor "tri", degreasing) ___Yes ___No
6. Perchloroethylene (perchlor, perc, dry-cleaning industry) ___Yes ___No
7. Pesticides ___Yes ___No
8. Methyl butyl keytone (MEK, inks) ___Yes ___No
9. Carbon Disulfide (rayon/rubber industry, labs) ___Yes ___No
10. Lead (jewelry, foundries, battery industries, ammunition) ___Yes ___No
11. Toluene (solvents, lacquers, inks) ___Yes ___No
12. Methylene Chloride ___Yes ___No
13. Carbon Monoxide (by-products of combustion) ___Yes ___No
14. Fumes or hazardous Gases ___Yes ___No
15. Asbestos ___Yes ___No
16. Industrial dust or flames ___Yes ___No
17. Radioactive material, lasers, x-rays, radar ___Yes ___No
18. Frequent or prolonged exposure to extreme temperatures ___Yes ___No
19. Loud industrial noise ___Yes ___No
20. Firearms/guns ___Yes ___No
21. Frequent or prolonged use of a chain saw ___Yes ___No
22. Frequent or prolonged use of lawn equipment or chippers ___Yes ___No
23. Frequent or prolonged exposure to motorcycle noise ___Yes ___No
24. Frequent or prolonged use of industrial equipment that causes vibrations (e.g.jackhammers) ___Yes ___No

If yes, describe by number the exposure and estimate dates and duration of exposure:

Do you have any hobbies which could expose you to glues, solvents, or chemicals?

Painting	___Yes ___No
Furniture Refinishing	___Yes ___No
Lead Glass Making	___Yes ___No
Auto Body Work	___Yes ___No
Jewelry Making	___Yes ___No
Pottery Making or Ceramics	___Yes ___No
Other (please explain):	

If Yes, estimate time involved in the activity:

To the best of your knowledge, have you ever had an illness or symptoms resulting from exposure to a chemical or hazardous materials? ___Yes ___No

If Yes, give date(s) and explain:

In the past 5 years, have you regularly worn any of the following protective equipment in your previous work?

Ear plugs/muffs	___Yes ___No
Goggles/face mask	___Yes ___No
Dust mask	___Yes ___No
Respirator	___Yes ___No
Gloves	___Yes ___No
Apron, gown	___Yes ___No
Other (please explain):	

Are you or have you been in the past 5 years a volunteer firefighter or cadet with Montgomery County, MD? ___Yes ___No

If Yes, Explain:

I certify that I have reviewed the foregoing information supplied by me and that it is true and complete to the best of my knowledge. Further, I understand the following:

1. That any offer of employment is conditioned on the results of this medical evaluation.

2. Any intentionally false or misleading statement may result in the rejection of my application for employment or in my discharge from County employment. Such a false or misleading statement may also exclude me from coverage in the County medical disability retirement or disability benefit programs.

3. That I may be required to provide additional medical information and/or undergo further medical evaluation as a condition of employment.

Applicant's
Signature_____Date_____

****

Physician/Nurse comments, summary, or elaboration of all pertinent data.

Physician/Nurse Signature _____Date_____
Revised 10/2000

Montgomery County Government
Fire/Rescue Occupational Medical Services
Medical History Form for Assessing Readiness
For Respirator Mask Fitting

To the employer: Answers to questions in Section 1, and to question 9 in Section 2 of Part A, do not require a medical examination.

Can you read (circle one): Yes/No

Note to employer: If the employee indicates he/she cannot read, he/she is to be referred to OMS for assistance in completing the questionnaire.

Your employer must allow you to answer this questionnaire during normal working hours, or at a time and place that is convenient to you. To maintain your confidentiality, your employer or supervisor must not look at or review your answers, and your employer must tell you how to deliver or send this questionnaire to the health care professional who will review it.

Please read: Please complete this questionnaire during your work hours. Be sure to answer all questions as thoroughly as possible. When you have finished, place the form in an envelope marked 'Confidential', seal it, and send it to Occupational Medical Services [OMS]. If the Employee Medical Examiner determines an examination is necessary, you will be notified to schedule an appointment.

Part A Section 1. (Mandatory) The following information must be provided by every employee who has been selected to use any type of respirator (please print).

1. Today's date:_____ Your name: _____

2. Fire Service Number:_____ Social Security #: _ _ _ - _ _ - _ _ _ _

3. Your age (to nearest year):_____ 4. Sex (circle one): Male/Female

5. Your height: ____ ft. ____ in. 6. Your weight: _____ lbs.

7. Your job title: _____ Sta #: _____ Dept. Contact: _____

8. A phone number where you can be reached by OMS: _____

9. The best time to phone you at this number: _____

10. Your Address (street, state, zip code) _____

_____

10. Has your employer told you how to contact the health care professional who will review this questionnaire (circle one): Yes/No

11. Check the type of respirator you will use (you can check more than one category):

a. ____ N, R, or P disposable respirator (filter-mask, non-cartridge type only).
b. ____ Other type (for example, half- or full-face piece type, powered-air purifying, supplied-air, self-contained breathing apparatus).

12. Have you worn a respirator (circle one): Yes/No

If "yes," what type(s):_____

_____

Montgomery County Government
Fire/Rescue Occupational Medical Services
Medical History Form for Assessing Readiness
For Respirator Mask Fitting

Part A Section 2. (Mandatory) Questions 1 through 9 below must be answered by every employee who has been selected to use any type of respirator (please circle "yes" or "no").

1. Do you **currently** smoke tobacco, or have you smoked tobacco in the last month? Yes No

2. Have you **ever had** any of the following conditions?

a. Seizures (fits)	Yes	No
b. Diabetes (sugar disease)	Yes	No
c. Allergic reactions that interfere with your breathing	Yes	No
d. Claustrophobia (fear of closed-in places)	Yes	No
e. Trouble smelling odors	Yes	No

3. Have you **ever had** any of the following pulmonary or lung problems?

a. Asbestosis	Yes	No
b. Asthma	Yes	No
c. Chronic bronchitis	Yes	No
d. Emphysema	Yes	No
e. Pneumonia	Yes	No
f. Tuberculosis	Yes	No
g. Silicosis	Yes	No
h. Pneumothorax (collapsed lung)	Yes	No
i. Lung cancer	Yes	No
j. Broken ribs	Yes	No
k. Any chest injuries or surgeries	Yes	No
l. Any other lung problem that you've been told about	Yes	No

4. Do you **currently** have any of the following symptoms of pulmonary or lung illness?

a. Shortness of breath	Yes	No
b. Shortness of breath when walking fast on level ground or walking up a slight hill or incline	Yes	No
c. Shortness of breath when walking with other people at an ordinary pace on level ground	Yes	No
d. Have to stop for breath when walking at your own pace on level ground	Yes	No
e. Shortness of breath when washing or dressing yourself	Yes	No
f. Shortness of breath that interferes with your job	Yes	No
g. Coughing that produces phlegm (thick sputum)	Yes	No
h. Coughing that wakes you early in the morning	Yes	No
i. Coughing that occurs mostly when you are lying down	Yes	No
j. Coughing up blood in the last month	Yes	No
k. Wheezing	Yes	No

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Medical History Form for Assessing Readiness
For Respirator Mask Fitting

l. Wheezing that interferes with your job	Yes	No
m. Chest pain when you breathe deeply	Yes	No
n. Any other symptoms that you think may be related to lung problems	Yes	No

5. Have you **ever had** any of the following cardiovascular or heart problems?

a. Heart attack	Yes	No
b. Stroke	Yes	No
c. Angina	Yes	No
d. Heart failure	Yes	No
e. Swelling in your legs or feet (not caused by walking)	Yes	No
f. Heart arrhythmia (heart beating irregularly)	Yes	No
g. High blood pressure	Yes	No
h. Any other heart problem that you've been told about	Yes	No

6. Have you **ever had** any of the following cardiovascular or heart symptoms?

a. Frequent pain or tightness in your chest	Yes	No
b. Pain or tightness in your chest during physical activity	Yes	No
c. Pain or tightness in your chest that interferes with your job	Yes	No
d. In the past two years, have you noticed your heart skipping or missing a beat	Yes	No
e. Heartburn or indigestion that is not related to eating	Yes	No
f. Any other symptoms that you think may be related to heart or circulation problems	Yes	No

7. Do you **currently** take medication for any of the following problems?

a. Breathing or lung problems	Yes	No
b. Heart trouble	Yes	No
c. Blood pressure	Yes	No
d. Seizures (fits)	Yes	No

8. If you've used a respirator, have you **ever had** any of the following problems? (If you've never used a respirator, check the following space and go to question 9:) ___

a. Eye irritation	Yes	No
b. Skin allergies or rashes	Yes	No
c. Anxiety	Yes	No
d. General weakness or fatigue	Yes	No
e. Any other problem that interferes with your use of a respirator	Yes	No

9. Would you like to talk to the health care professional who will review this questionnaire about your answers to this questionnaire? Yes No

Montgomery County Government
Fire/Rescue Occupational Medical Services
Medical History Form for Assessing Readiness
For Respirator Mask Fitting

Questions 10 to 15 below must be answered by every employee who has been selected to use either a full-face piece respirator or a self-contained breathing apparatus (SCBA). For employees who have been selected to use other types of respirators, answering these questions is voluntary.

10. Have you **ever lost** vision in either eye (temporarily or permanently) Yes No

11. Do you **currently** have any of the following vision problems?

a. Wear contact lenses Yes No
b. Wear glasses Yes No
c. Color blind Yes No
e. Any other eye or vision problem Yes No

12. Have you **ever had** an injury to your ears, including a broken ear drum? Yes No

13. Do you **currently** have any of the following hearing problems?

a. Difficulty hearing Yes No
b. Wear a hearing aid Yes No
c. Any other hearing or ear problem Yes No

14. Have you **ever had** a back injury? Yes No

15. Do you **currently** have any of the following musculoskeletal problems?

a. Weakness in any of your arms, hands, legs, or feet Yes No
b. Back pain Yes No
c. Difficulty fully moving your arms and legs Yes No
d. Pain or stiffness when you lean forward or backward at the waist Yes No
e. Difficulty fully moving your head up or down Yes No
f. Difficulty fully moving your head side to side Yes No
g. Difficulty bending at your knees Yes No
h. Difficulty squatting to the ground Yes No
i. Climbing a flight of stairs or a ladder carrying more than 25 lbs Yes No
j. Any other muscle or skeletal problem that interferes with using a respirator Yes No

Part B Any of the following questions, and other questions not listed, may be added to the questionnaire at the discretion of the health care professional who will review the questionnaire.

1. In your present job, are you working at high altitudes (over 5,000 feet) or in a place that has lower than normal amounts of oxygen? Yes No

If "yes," do you have feelings of dizziness, shortness of breath, pounding in your chest or other symptoms when you're working under these conditions? Yes No

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For Respirator Mask Fitting

2. At work or at home, have you ever been exposed to hazardous solvents, hazardous airborne chemicals (**e.g.**, gases, fumes, or dust), or have you come into skin contact with hazardous chemicals? Yes No

If "yes," name the chemicals if you know them:_____
_____
_____

3. Have you ever worked with any of the materials, or under any of the conditions, listed below?

a. Asbestos	Yes	No
b. Silica (**e.g.**, in sandblasting)	Yes	No
c. Tungsten/cobalt (**e.g.**, grinding or welding this material)	Yes	No
d. Beryllium	Yes	No
e. Aluminum	Yes	No
f. Coal (for example, mining)	Yes	No
g. Iron	Yes	No
h. Tin	Yes	No
i. Dusty environments	Yes	No
j. Any other hazardous exposures	Yes	No

If "yes," describe these exposures:_____
_____
_____

4. List any second jobs or side businesses you have:_____
_____

5. List your previous occupations:_____
_____

6. List your current and previous hobbies:_____
_____

7. Have you been in the military services? Yes No

If "yes," were you exposed to biological or chemical agents (either in training or combat)? Yes No

8. Have you ever worked on a HAZMAT team? Yes No

9. Other than medications for breathing and lung problems, heart trouble, blood pressure, and seizures mentioned earlier in this questionnaire, are you taking any other medications for any reason (including over-the-counter medications)? Yes No

If "yes," name the medications if you know them:_____

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Fire/Rescue Occupational Medical Services
Medical History Form for Assessing Readiness
For Respirator Mask Fitting

10. Will you be using any of the following items with your respirator(s)?

a. HEPA Filters	Yes	No
b. Canisters (for example, gas masks)	Yes	No
c. Cartridges	Yes	No

11. How often are you expected to use the respirator(s)? (Circle "yes" or "no" for all answers that apply to you)

a. Escape only (no rescue)	Yes	No
b. Emergency rescue only	Yes	No
c. Less than 5 hours **per week**	Yes	No
d. Less than 2 hours **per day**	Yes	No
e. 2 to 4 hours per day	Yes	No
f. Over 4 hours per day	Yes	No

12. During the period you are using the respirator(s), is your work effort:

a. **Light** (less than 200 kcal per hour) Yes No

If "yes," how long does this period last during the average shift? ____hrs.___mins.

Examples of a light work effort are **sitting** while writing, typing, drafting, or performing light assembly work; or **standing** while operating a drill press (1-3 lbs.) or controlling machines.

b. **Moderate** (200 to 350 kcal per hour) Yes No

If "yes," how long does this period last during the average shift ____hrs. ___mins.

Examples of moderate work effort are **sitting** while nailing or filing; **driving** a truck or bus in urban traffic; **standing** while drilling, nailing, performing assembly work, or transferring a moderate load (about 35 lbs.) at trunk level; **walking** on a level surface about 2 mph or down a 5-degree grade about 3 mph; or **pushing** a wheelbarrow with a heavy load (about 100 lbs.) on a level surface.

c. **Heavy** (above 350 kcal per hour) Yes No

If "yes," how long does this period last during the average shift ____hrs. ___mins.

Examples of heavy work are **lifting** a heavy load (about 50 lbs.) from the floor to your waist or shoulder; working on a loading dock; **shoveling; standing** while bricklaying or chipping castings; **walking** up an 8-degree grade about 2 mph; climbing stairs with a heavy load (about 50 lbs.).

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13. Will you be wearing protective clothing and/or equipment (other than the respirator) when you're using your respirator? Yes No

    If "yes," describe this protective clothing and/or equipment:_____

    _____

14. Will you be working under hot conditions (temperature exceeding 77 deg. F)? Yes No

15. Will you be working under humid conditions? Yes No

16. Describe the work you'll be doing while you're using your respirator(s):

    _____

    _____

17. Describe any special or hazardous conditions you might encounter when you're using your respirator(s) (for example, confined spaces, life-threatening gases):

    _____

    _____

18. Provide the following information, if you know it, for each toxic substance that you'll be exposed to when you're using your respirator(s):

    Name of the first toxic substance:_____
    Estimated maximum exposure level per shift:_____
    Duration of exposure per shift_____
    Name of the second toxic substance:_____
    Estimated maximum exposure level per shift:_____
    Duration of exposure per shift:_____
    Name of the third toxic substance:_____
    Estimated maximum exposure level per shift:_____
    Duration of exposure per shift:_____
    The name of any other toxic substances that you'll be exposed to while using your respirator:

    _____

    _____

    _____

19. Describe any special responsibilities you'll have while using your respirator(s) that may affect the safety and well-being of others (for example, rescue or security):

I certify that all answers are complete and accurate to the best of my knowledge:

Signature _____ Date _____

Montgomery County
Office of Human Resources
Occupational Medical Services

Medical Determination of Readiness for Respirator Fit-Testing Form

Employee Name:_____ SS#:_____

Department: _____ Position:_____

To the Health Care Provider completing this form, check the appropriate items below:

_____ I certify that I have reviewed the 'Medical History Form for Assessing Readiness For Respirator Mask Fitting Form'

After completing the review of the above form, I certify:

___ The above named employee has been medically certified to wear a positive pressure self-contained breathing apparatus pending successful fit testing.

___ The above named employee *is not cleared* for wearing a respirator at this time. Further medical evaluation is necessary to make a final determination.

___ The above named employee may wear a negative pressure breathing apparatus with a tight full fit face piece pending successful fit testing.

___ The above named employee is not recommended for *any* respirator use.

___ The employee has been provided with a copy of this form.

The 'Medical History Form for Assessing Readiness For Respirator Mask Fitting Form' has been:

___ Filed in the employee's Occupational Medical Services medical record

___ Returned to the employee for his/her personal records

_____ _____
Employee Medical Examiner/other Provider Printed Name Provider's Signature

_____
Date of Signature

Dept. – White
Employee – Yellow
Employee Medical Record - Pink

Montgomery County Government
OCCUPATIONAL MEDICAL SERVICES
255 ROCKVILLE PIKE, SUITE 135
ROCKVILLE, MARYLAND 20850
(240) 777-5185 PHONE
(240) 777-5132 FAX

Tuberculin Skin Test

Patient Consent Statement: I certify that I have read the information on this form. I have had an opportunity to ask related questions and my questions were answered to my satisfaction. I believe that I understand the benefits and risks of taking a tuberculin test and I assume the risks. I request that the tuberculin test be given.

Name_____ Date of Birth_____

Address_____

County Job Title_____ Social Security Number_____

Have you ever tested positive to a tuberculin skin test in the past? _____ If yes, when?_____

If yes, what treatment was given to you at the time?_____

Signature of person to receive test_____ Date_____

****

For Clinic Use Only

Test # 1
Skin Test PPD 5TU 0.1 ml Lot #_____ Manufacturer_____
Expiration Date_____

Date Given_____ Right Forearm / Left Forearm (Circle One)

Date Read_____ Result_____mm

Signature/Title of Person Giving Test_____

Signature/Title of Reader_____

Test # 2
Skin Test PPD 5TU 0.1 ml Lot #_____ Manufacturer_____
Expiration Date_____

Date Given_____ Right Forearm / Left Forearm (Circle One)

Date Read_____ Result_____mm

Signature/Title of Person Giving Test_____

Signature/Title of Reader_____

If history of positive skin test review checklist given_____

Revised 2/03

MONTGOMERY COUNTY FIRE AND RESCUE COMMISSION

APPLICANT DRUG/ALCOHOL TESTING NOTIFICATION

(Please print or type)

I, _____, understand that a urine screen for the presence of drugs/alcohol administered by Montgomery County Fire Rescue Occupational Medical Services, is a condition of my volunteer service. I further understand that the results of this urine screen will be released only to me and Montgomery County Fire Rescue Occupational Medical Services, and will be used solely to complete my application for volunteer service. The results of this screen will not be disclosed without my written consent to another person or agency for any other purpose, including any administrative, civil, or criminal proceeding.

I, _____, have been informed that Laboratory Corporation of America is the certified laboratory which will perform drug/alcohol testing on my urine specimen collected on _____in Fire Rescue Occupational Medical Services. I understand that I have the right to request independent testing of the same specimen at my own expense at another Federal and State certified laboratory if my urine specimen tests positive for drugs and/or alcohol.

_____

Print Name

_____ _____

Signature Date

Rev 3/03

Montgomery County Government
Fire Rescue Occupational Medical Services (FROMS)
Authorization to Obtain Specimen for Drug/Alcohol Testing

Reason for Test [Check One]:

[ ] Pre-Employment

I authorize Fire Rescue Occupational Medical Services (FROMS) of the Montgomery County Government or any doctor, nurse, technician, laboratory personnel at any laboratory or medical center designated by Montgomery County Government to collect a ____ urine specimen for drug/alcohol testing. My specimen was given on [enter date] _____ at FROMS.

I have been informed that the laboratory named below will perform the urine/blood test for drugs/alcohol and that this laboratory has been certified by the State of Maryland and the U.S. Department of Health and Human Services to perform employment-related drug/alcohol testing:

Name of Laboratory: LabCorp

If the urine specimen is found to be positive for drugs/alcohol, I understand that I am entitled to have the same specimen tested independently at a different laboratory which has been certified by the State of Maryland and the U.S. Department of Health and Human Services. If I elect to have the specimen tested independently, I must pay the costs of the test. A list of certified laboratories is available at Occupational Medical Services.

I understand that the laboratory will report the drug/alcohol test results to the Employee Medical Examiner of Montgomery County Government, Fire Rescue Occupational Medical Services. A photocopy of this authorization will be as valid as the original, even though the photocopy does not contain an original writing of my signature.

Applicant/Employee Printed Name: _____

Signature: _____ Last 4 Digits of SSN _____

Address: _____

Witness: _____ Date: _____

Montgomery County Government
Fire Rescue Occupational Medical Services (FROMS)
Non-DOT Authorization for Release of Information Related to Drug/Alcohol Testing

Reason for Test [Check One]:

[ ] Pre-employment

I, _____, authorize the release of the results of the drug/alcohol testing by the laboratory which conducted the test to the Employee Medical Examiner of Fire Rescue Occupational Medical Services (FROMS) of the Montgomery County Government at 255 Rockville Pike, Suite 135, Rockville, MD 20850.

I further authorize FROMS to release the results of the drug/alcohol test as a finding of negative or confirmed positive to _____.
[Fire Chief or Designee]

If I am a current County employee who is applying for a transfer to, or appointment in, a position in a different County department or agency, or if I am a County employee who is applying for a promotion within my current department (and submission to pre-employment drug testing is a prerequisite to appointment to the higher-level position), I understand that any confirmed positive drug or alcohol test result will also be reported to the director of the County department or agency in which I am currently employed.

This authorization is limited to information derived from the tests and evaluation performed on my _____ urine specimen obtained on _____ [insert date] at FROMS.

This authorizes the release of this information solely to enable Montgomery County Government to make employee-related decisions.

A photocopy of this authorization will be considered as valid as the original, even though the photocopy does not contain an original writing of my signature.

Applicant/Employee Printed Name: _____

Signature: _____ Last 4 digits of SS# _____

Witness: _____ Date: _____

Montgomery County Fire/Rescue Occupational Medical Services
255 Rockville Pike, Suite 135
Rockville, Maryland 20850
Phone: 240-777-5185

PARENTAL CONSENT FORM

To: Montgomery County Employee Medical Examiner

I am the parent/legal guardian of _____. I
(volunteer applicant)
hereby authorize the Montgomery County Occupational Medical Section to give the above named individual a medical examination which includes a chest x-ray, an exercise treadmill test, the drawing of blood and a tuberculin skin test. This medical examination is in connection with the participation as a volunteer by the above named individual with the _____. I hereby consent to the above
(corporation)
named individual performing hazardous work as a firefighter / rescuer / EMT for _____. I further certify that the
(corporation)
above individual is at least 16 years old and has completed or will be taking a course of study about firefighting, rescue, or basic emergency care.

_____ _____
Signature of Parent or Guardian *Date*

Approved 5/10/10
SAM

Montgomery County Government
Office of Human Resources
Fire/Rescue Occupational Medical Services

Consent Form for Collection -- Pre-employment Drug/Alcohol Testing

I, _____, the parent/guardian of _____,
[Parent/Guardian printed name] [Minor's printed name]
authorize Montgomery County Occupational Medical Services [OMS] to perform a medical examination on the above named individual. I certify that the above named individual is at least sixteen (16) years old.

I understand that the examination will include collection of a urine specimen to be tested for drugs and alcohol. The process for evaluating the specimen is as follows:

1. The individual completes the 'Authorization To Obtain Specimen' and the 'Authorization for Release of Information Relating to Drug/Alcohol Testing' forms and signs and dates them.
2. A specimen is collected from the individual, separated into containers to allow future retesting, and sent to the lab with the appropriate custody and control forms
3. The results are received in OMS and reviewed by the Employee Medical Examiner [EME]
4. If the results are positive, the EME will call the individual who gave the specimen to conduct a telephone interview to determine if there is any medical indication for the positive result. If there is a medical indication for the results, the EME will certify the results as negative. If the EME determines there is no medical indication for the positive result, he will certify the drug screen results as confirmed positive and inform the individual of the right to a retest.
5. The EME will make three (3) reasonably spaced attempts within a 24-hour period to reach the individual to discuss the results before making his determination and certification.
6. If the EME is unable to reach him/her, or once the EME has spoken to the individual and confirmed the results as positive, a memorandum of notification of the positive results will be sent to the Manager in the Office of Human Resources (OHR) ten (10) days after the EME has determined the results to be positive. If the tenth day falls on a weekend or a holiday, the memo is sent on the next business day. A copy of the memo sent to OHR and a copy of the individual's drug screen results are sent, via certified mail, to the individual and, if the individual is a minor, also to the parent or guardian identified below.

_____ I do not wish to be included in the telephone discussion of results for my minor child.

_____ Please include me in the discussion of results with my minor child. I can be reached at the following number from 8 AM – 4:30 PM Monday through Friday.
(____) _____-_____

I understand that the EME will discuss the results with my minor child if I am unable to be reached at the above number within 3 attempts.

_____ _____
Parent/Guardian Printed Name Parent/Guardian Signature

Date _____

Rev. 8/04